PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	The current health of the signing Deaf community in the UK compared with the general population: a cross-sectional study
AUTHORS	Emond, Alan; Ridd, Matthew; Sutherland, Hilary; Allsop, Lorna; Alexander, Andrew; Kyle, Jim

VERSION 1 - REVIEW

REVIEWER	Johannes Fellinger, MD PD Hospital St. John of God Institut for Neurology of Senses and Language Austria
REVIEW RETURNED	04-Nov-2014

GENERAL COMMENTS	The paper "The health of Deaf People in the UK" addresses for the first time the health situation of members of the signing Deaf community in UK by the use of standardised health assessments in sign language. Therefore this research is unique and of outstanding importance despite numerous limitations which are also stated by the authors. Having this in mind a more specific and modest title could be appropriate, like "Findings on health in the signing Deaf community in UK". This recommendation is majorly justified by the selection of the sample which propably was constituted by more health conscious activ members with adequate sign language competence. The description of the sampling process indicates that participants were volunteers from different regions. Epidemiological data from the Deaf communities they come from are not given to compare their characteristics with - however this might be impossible. The second mayor point of concern is the imbalance how the authors report and discuss the findings. Disparities in access to health information and health care with respect to obesity, high blood pressure and diabetes are pointed out clearly whereas the findings on lower rates of self-reported cardiovascular disease, elevated colesterol and self-reported smoking habits are not discussed sufficiently. The low rate of smokers for instance could explain the lower incidence of cardiovascular disease despite higher rates of other risk factors. This requires in depth discussion. With respect to depression it would be helpful to get more information about the questions the participants were asked and about possibilities to compare the findings with data from the general

	population. I would be happy to review a revised and more comprehensive version.

REVIEWER	Robert Pollard University of Rochester School of Medicine USA
REVIEW RETURNED	13-Nov-2014

GENERAL COMMENTS	This is one of very, very few manuscripts I would be happy to see published "as is." My congratulations to the authors for doing a fine, and important, research study and producing this excellent manuscript. The only things I found lacking in this study were the failure to record and analyze education level and annual income information as well as various "deaf demographics" that might shed further light on these results. By deaf demographics, I mean such things as cultural affiliation/identification (Deaf, deaf, hard-of-hearing), severity and age of onset of hearing loss (even if self-reported), whether or not the participant had/has deaf parents or deaf siblings, and fluency in both BSL and English (even if self-reported).

VERSION 1 – AUTHOR RESPONSE

Reviewer 1
1. Having this in mind a more specific and modest title could be appropriate, like "Findings on health in the signing Deaf community in UK". This recommendation is majorly justified by the selection of the sample which probably was constituted by more health conscious active members with adequate sign language competence.

Response: We have changed the title to ‘The health status of the sign language-using Deaf community in the UK’

2. The description of the sampling process indicates that participants were volunteers from different regions. Epidemiological data from the Deaf communities they come from are not given to compare their characteristics with - however this might be impossible.

Response: participants were recruited to a sampling frame pre-determined according to the age and gender distribution of the general population of the UK in the most recent census. No useful register exists of Deaf people, and no epidemiological data are available on the Deaf community in the UK. Since the Deaf community have limited literacy, the participants had to be approached directly by Deaf agents. Strictly speaking, they are not volunteers (recruited openly) but rather were approached in each area according to the sampling targets.

3. The second mayor point of concern is the imbalance how the authors report and discuss the findings. Disparities in access to health information and health care with respect to obesity, high blood pressure and diabetes are pointed out clearly whereas the findings on lower rates of self-reported cardiovascular disease, elevated cholesterol and self-reported smoking habits are not discussed sufficiently.
The low rate of smokers for instance could explain the lower incidence of cardiovascular disease

despite higher rates of other risk factors. This requires in depth discussion.

Response: We have added a paragraph to the discussion about the lower rates of smoking and potential relationship with reported cardiovascular disease, in the context of high rates of obesity and raised blood pressure.

4. With respect to depression it would be helpful to get more information about the questions the participants were asked and about possibilities to compare the findings with data from the general population.

Response; We have clarified the question asked about depression. Because of the difficulty in defining 'depression' in a simple self-reported question, we have compared the self- reported treatment rates with anti-depressants with the NHS Quality Outcomes framework data on anti-depressant prescription in the general population
The primary concern in this study was to look at general health outcomes, hence we used only a simple self-report question on whether the participant had experienced depression. This was compared to the treatment rates based on the participants supplying their medications list. Our rationale was that there is already considerable data suggesting that depression (in particular) has a higher incidence in the Deaf sign language using community (eg Kvam MH and Loeb M Mental Health in Deaf Adults: Symptoms of Anxiety and Depression Among Hearing and Deaf Individuals, J. Deaf Stud. Deaf Educ. (2007) 12 (1): 1-7.)

Reviewer 2
The only things I found lacking in this study were the failure to record and analyze education level and annual income information as well as various "deaf demographics" that might shed further light on these results. By deaf demographics, I mean such things as cultural affiliation/identification (Deaf, deaf, hard-of-hearing), severity and age of onset of hearing loss (even if self-reported), whether or not the participant had/has deaf parents or deaf siblings, and fluency in both BSL and English (even if self-reported).

Response: We accept that some more detail on the background of respondents might have been useful. All participants were culturally Deaf, and BSL was their first language. We expect that just over half of the sample to have learned sign language after the age of five years - a figure which is repeated over most of Europe for this age range of Deaf people (Kyle & Allsop, 1998). We did not record fluency in English, but it varied greatly amongst participants, so all study materials were translated into BSL. Measurement of hearing loss would not have been ethically acceptable to these participants nor would measurement of sign competence or English levels.

VERSION 2 – REVIEW

REVIEWER	Johannes Fellinger, MD PD Hospital St. John of God Institute for Neurologgy of Senses and Language Austria
REVIEW RETURNED	09-Dec-2014

GENERAL COMMENTS	Thank you for contributing to improve access to Health care for people who are Deaf by your research.

REVIEWER	Robert Pollard University of Rochester School of Medicine, U.S.A
REVIEW RETURNED	18-Dec-2014

GENERAL COMMENTS	Thank you for this excellent work.